STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING _____ B. WING _____	C 06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/23/25 through 06/26/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GRXP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/23/25 through 06/26/25. Event ID #GRXP11. The following intakes were investigated: NC00221971, NC00222262, NC00224328, NC00224758, NC00230799, NC00230709, NC00231756 and NC00231869. 2 of the 16 complaint allegations resulted in deficiency.	F 000		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of wrong dosage (2 medication errors out of 30 opportunities), resulting in a medication error rate of 6.67% for 2 of 3 residents (Resident #105 and Resident #36) observed during medication pass. The findings included:	F 759	F759 Resident affected: Immediate retraining was conducted by the Director of Nursing (DON) with the nurse #1 and Nurse #2 regarding medication administration and correct dosages. This was completed on 6/25/2025. On 6/25/2025, Nurse #1 made	7/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/10/2025

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F 759	Continued From page 1 1. Resident #105 was admitted to the facility on 3/24/25 with diagnoses that included vitamin deficiency. The Physician's Orders in Resident #105's electronic medical record indicated an active order dated 3/24/25 for Cholecalciferol (Vitamin D3) 50 micrograms (mcg) (2000 units) once a day. On 6/25/25 at 8:16 AM, Nurse #1 was observed as she prepared and administered Resident #105's medications. Nurse #1 administered one tablet of Vitamin D3 25 mcg to Resident #105. An interview with Nurse #1 on 6/25/25 at 9:38 AM revealed she should have given two tablets of Vitamin D3 to Resident #105 when she gave her medications. An interview with the Director of Nursing (DON) on 6/25 /25 at 2:40 PM revealed she would need to check to see why Nurse #1 made the medication error, but it was probably because she didn't read the label on the bottle carefully. The DON stated that the nurses were supposed to follow the five rights of medication administration. 2. Resident #36 was admitted to the facility on 2/9/23 with diagnoses that included vitamin D deficiency. The Physician's Orders in Resident #36's electronic medical record indicated an active order dated 2/12/23 for Cholecalciferol (Vitamin D3) 50 mcg (2000 units) once a day. On 6/25/25 at 8:40 AM, Nurse #2 was observed	F 759	dosage correction for Resident #105 ensuring the correct dosage of Cholecalciferol (Vitamin D3) micrograms (mcg) (2000 units) was administered. On 06/25/2025, Nurse # 2 made dosage correction for Resident #36 ensuring the correct dosage of Cholecalciferol (Vitamin D3) 50 mcg (2000) Resident #105 and Resident #36 were not adversely affected by the alleged deficient practice. Other residents with potential to be affected: DON observed Licensed Nurse #1 and SDC observed Nurse #2 for the remainder of medication administration to ensure no other medication dosage errors. There were no additional residents identified to have been affected by the alleged deficient practice. System corrective action: The DON and SDC will educate all Licensed Nurses and Medication Aides (MA) on medication pass and dosages. This education will be completed by 7/12/2025. Any Licensed Nurses or Medication Aides out on leave, vacation or PRN status will be educated by the DON or SDC prior to returning to their assignment. All newly hired Nurses or MA are educated on this policy and procedure during orientation by the SDC or DON. Education specifically on correct dosage and specifically on dosage of Vitamin D.	

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F 759	Continued From page 2 as she administered Resident #36's medications. Nurse #1 administered two tablets of Vitamin D3 10 mcg (400 units) to Resident #36. An interview with Nurse #2 on 6/25/25 at 9:11 AM revealed she was aware that the facility had two different formulations of Vitamin D3 available, and that she should have pulled from the other bottle of Vitamin D3 that had 50 mcg to give the correct dose to Resident #36. An interview with the Director of Nursing (DON) on 6/25 /25 at 2:40 PM revealed she would need to check to see why Nurse #2 made the medication error, but it was probably because she didn't read the label on the bottle carefully. The DON stated that the nurses were supposed to follow the five rights of medication administration.	F 759	Monitoring: DON or SDC to audit two licensed nurses and/or medication aides using Medication Pass Worksheet for Licensed Nursing and MA staff during medication pass on all shifts randomly twice a week for 4 weeks and then once weekly for 4 weeks, then biweekly x 4 weeks to ensure continued compliance. Audits will be specifically on correct dosage given during medication administration. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		7/13/25

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F 812	Continued From page 3 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to remove expired milk from the kitchen's walk-in refrigerator for 1 of 1 walk-in refrigerator. Findings included On 6/23/225 at 10:48 AM an observation of the walk-in refrigerator with the Dietary Manager (DM) found a crate located on the second shelf containing approximately 12-pint size milk cartons stamped with a expiration date of 6/17/25. On 6/25/25 at 11:19 AM the DM stated the expired milk should have been removed by the expiration date. The DM stated it was her responsibility to ensure the walk-in refrigerator food items were not stored past their expiration date. Furthermore, the DM stated she had overlooked the milk and she checked the walk-in refrigerator daily. The Administrator was interviewed on 6/26/25 at 3:22 PM and stated the expired milk should have been removed from the refrigerator by the expiration date.	F 812	F812 Peak Resources Charlotte acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Affected Resident: It is expected that our facility will provide food to residents that is stored, procured, prepared, and served in a sanitary manner. No residents suffered any adverse effects related to the alleged deficient practice. On 6/23/25 the Dietary Manager and District Dietary Manager disposed of the 12-pint size milk cartons with an expiration date of 6/17/2025. Potentially Affected Resident: All residents have the potential to be	

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F 812	Continued From page 4	F 812	affected by the alleged deficient practice. On 06/23/2025, the District Dietary manager checked all other food items in the walk-in refrigerator to check the expiration date. There were no other items to be discarded. Measures/Systemic Changes: The District Dietary manager educated the Dietary Manager and all the kitchen staff on the following by 07/12/2025: Complete inspection of walk-in refrigerator ensure items are discarded by the expiration date. Monitoring: An audit tool was developed to ensure all items in the walk-in refrigerator have been discarded by the expiration date written on the package and will be completed weekly by the Dietary Manager for 8 weeks. The results of the audits will be brought to the Quality Assurance and Performance Improvement Committee by the respective auditors monthly x 2 months for review and further recommendations.	